DEPARTMENT OF FINANCIAL SERVICES
Division of Treasury – Bureau of Deferred Compensation

STATE OF FLORIDA DEFERRED COMPENSATION PLAN

ROLLOVER INTO/OUT OF FLORIDA PLAN

Please print clearly in ballpoint pen, and press firmly to ensure that all copies are completed. Initial any corrections or changes.

Investment Provider:

Section 1 - PARTICIPANT INFORMATION: (Please PRINT NAME EXACTLY as reported to your payroll office)

Name (First, MI, Last) _____ SSN* _____

Street Address: _____ ☐ Male ☐ Female

City: _____ State: _____ Zip: _____ Date of Birth: _____ / _____ / _____

Phone Numbers: Home (_____)_____ Work (_____)_____Email Address: _____

***Your disclosure of your social security number or taxpayer identification number is required. Section 112.215 F.S. authorizes the creation of the State of Florida Deferred Compensation Plan, which is intended to qualify for tax deferral pursuant to 26 USC 457. Use of the identifying numbers is mandated by 26 USC 6109. Your social security number or taxpayer identification number will be used as an identifying number for purposes of federal tax law.**

Why are you completing this form?

☐Full or ☐Partial Rollover Amount: $_____

I wish to rollover my funds FROM:	TO:
☐ 401 (a) (DROP)	☐ 457 (Deferred Compensation)
☐ 401(k)	☐ 403 (b)
☐ 403 (b)	☐ 401 (k)
☐ Traditional IRA	☐ Traditional IRA
☐ 457 (Deferred Compensation)	☐ 401A-FRS Investment Plan

Please Read Carefully:

You may not roll funds OUT of the Florida Plan until/unless you have separated from service with the State of Florida (This request will not be processed until 31 days past your last official workday)

For Transfers OUT only: Last Official Work Day ☐☐/☐☐/☐☐ This can be verified by calling my personnel office:
Name _____Title _____ Phone # ☐☐☐-☐☐☐-☐☐☐☐

All transfers OUT of State 457 require a letter of acceptance from the receiving entity. (Failure to submit a letter of acceptance will delay the Rollover Process.)

Note: Please consult your tax advisor prior to taking a distribution.

This section is to be completed by the investment provider with the State of Florida Plan

Section 2- For Funds Rolling Into The Florida Plan

From (Plan Name): _____
From (Investment Company): _____
Address _____
_____
Phone # _____

Contact Person/Representative _____
Phone # (if different from above) _____

(Due to the processing required to transfer a Deferred Compensation account, receipt of payment cannot be expected for four to six weeks after your completed paperwork has been received by our office)

Section 3- For Funds Rolling Out of The Florida Plan

Make check payable to: _____
(Name of Receiving Company)
Mail check to: _____
_____
_____

Special Instructions: _____
_____

_____ _____
Participant Signature Date State Office or other Authorized Signature Date

_____ _____
Deferred Compensation Specialist Signature Date Deferred Compensation Specialist (Print Name)